1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12973

CERTIFICATE OF DEATH

12984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels (rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: ALAN — Last: ACKERMAN

4. DATE OF DEATH: Month: 9 — Day: 16 — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1/22/1899

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive electrical

10b. KIND OF BUSINESS OR INDUSTRY: Supply Co.

11. BIRTHPLACE (County & State, or foreign country): Hudson Co. N.J.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Ackerman

14. MOTHER'S MAIDEN NAME: Dorothy Stelelzle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes WWI

16. SOCIAL SECURITY NO.: 138-22-8404

17. INFORMANT: Mrs. John A. Ackerman — Address: St. Michaels. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on Sept 16 1967 and that death occurred at 5:15 A M, from causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/20/67

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/19/1967

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill

23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: Maurice F. Newnam & Son — **ADDRESS**: Easton, Md

25a. REC'D BY REGISTRAR DATE: SEP 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12980 12985

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: TALBOT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL RIDGELY 05.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DALLAS Middle AUSTIN Last ADKINS

4. DATE OF DEATH: Month 9 Day 27 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 18, 1910

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LUMBER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: EVERETT ADKINS

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): MRS. EUGENIA ADKINS, RIDGELY MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sub-arachnoid hemorrhage, left — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
330X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on September 19 67, and that death occurred at 9:40 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 27 Sept 67

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL CREMATION REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 30, 1967

23c. NAME OF CEMETERY OR CREMATORY: RIDGELY

23d. LOCATION (City or Town) (County) (State): RIDGELY MARYLAND

24. FUNERAL DIRECTOR: Clarence Moore

ADDRESS: Denton

25a. REC'D BY REGISTRAR DATE OCT 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12981

CERTIFICATE OF DEATH

12986

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Easton
c. LENGTH OF STAY IN 1b: 13½ hrs.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): BURRSVILLE 46.3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress): Memorial Hosp.

3. NAME OF DECEASED (Type or print): First: Katherine Middle: Harriett Last: Baker

4. DATE OF DEATH: Month: 9 Day: 8 Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ~~FEB. 15, 1906~~ 26, 1906

9. AGE (Last birthday) 60 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN SINGER

14. MOTHER'S MAIDEN NAME: LIBBY MURPHY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknawn): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: PAUL SINGER, Address: DENTON MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: uncertain
DUE TO
(b): Rheumatic heart disease with (inactive) mitral regurgitation and atrial fibrillation
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
410 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Month, Day, Year Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at wark ☐

20e. PLACE OF INJURY (Hame, form, factory, street, affice bldg., etc.)

20f. (City or tawn) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 9-7, 19 67, to ____, 19 ___, that (I) (we) last saw the deceased alive an 9-8 19 67, and that death accurred at 2:55 A M, fram causes and an the date stated above.

22a. SIGNATURE: Robert W. Trever — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/67

22c. PHYSICIAN'S NAME (Type) Robert W. Trever M. D.

22d. ADDRESS: Easton, Maryland 9/8/67

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: SEPT. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: DENTON

23d. LOCATION (City or Town) (County) (State): DENTON MD

24. FUNERAL DIRECTOR: CHARLES V. MOORE ADDRESS: DENTON

25a. REC'D BY REGISTRAR DATE: SEP 14 1967

25b. REGISTRAR'S SIGNATURE:

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12987

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): II9 S. Hanson

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Easton
d. STREET ADDRESS: II9 S. Hanson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

20.1

3. NAME OF DECEASED (Type or print): First Delores — Middle — Lost Bostic
4. DATE OF DEATH: Month Sept. — Day 28 — Year 1967
5. SEX: F
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-3- I967
9. AGE (In years Last birthday): yrs.
IF UNDER 1 YEAR: Months 3 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mack Dawson
14. MOTHER'S MAIDEN NAME: Mildred Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mildred Mitchell — Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH
501X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Laryngotracheo Bronchitis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Lewis Whitty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): WELTY
Address (Street, city, town, or county):
22. DATE SIGNED: 9-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 9-29- I967
23c. NAME OF CEMETERY OR CREMATORY: Richards
23d. LOCATION (City or Town) (County) (State): Easton Talbot Md.

24. FUNERAL DIRECTOR: B.L. Dashiell — ADDRESS: Easton, Md.
25a. REC'D BY REGISTRAR DATE: OCT 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1
2
7-48

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12983 12988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Neavitt
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ----

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Neavitt
   d. STREET ADDRESS: ----
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ — 20.1

3. **NAME OF DECEASED** (Type or print): First: MARY — Middle: JANE — Last: BRIDGES

4. **DATE OF DEATH**: Month: September — Day: 2, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 23, 1893

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Talbot County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levin Fisher

14. MOTHER'S MAIDEN NAME: Frances Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 214-32-7095-B

17. INFORMANT — Address: Weldon Bridges, Neavitt, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): atherosclerotic cardiovasc.

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension Ext Vas.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1953, 19..., to 9-2-67, 19..., that (I) (we) last saw the deceased alive on 9-2 1967, and that death occurred at 1:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Guy M. Reeser M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-5-67

22c. PHYSICIAN'S NAME (Type): GUY M. REESER, Jr., M. D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Sept 4, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Neavitt Cemetery — 23d. LOCATION (City, town or county) (State): Neavitt, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Harrison E. Leonard, St. Michaels Md.

25a. REC'D BY REGISTRAR. DATE: SEP 6 1967 — 25b. REGISTRAR'S SIGNATURE: Juanita Judge

VR A1S 41
20M S-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12984 12989

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): Tilghman
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Tilghman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: — Last: Cummings

4. DATE OF DEATH: Month: 9/30 — Day — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white	☒ Married ☐ Never Married ☐ Widowed ☐ Divorced	7/15/1891	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Cummings
14. MOTHER'S MAIDEN NAME: Laura V. Birmingham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 218-05-8360
17. INFORMANT — Address: Mrs. Andrew Cummings, Tilghman, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b): coronary & cardio vasc'd.
Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema - severe
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Manth, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City or tawn) (Caunty) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 9-30-67, 19 30 to 9-30, 67, that (I) (we) last saw the deceased alive on 9-30 19 67 and that death accurred at 11 30 A.M., fram causes and an the date stated abave.

22a. SIGNATURE: Hugh M Reese Jr
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-2-67
22c. PHYSICIAN'S NAME (Type): Hugh M Reese Jr
22d. ADDRESS: 1 Mitchell Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/3/1967
23c. NAME OF CEMETERY OR CREMATORY: Pilgrim Holiness
23d. LOCATION (City or Tawn) (Caunty) (State): Tilghman, Md.

24. FUNERAL DIRECTOR — ADDRESS: MAURICE E. NEWNAM & SON, Easton, Md.
25a. REC'D BY REGISTRAR DATE: OCT 3 1967
25b. REGISTRAR'S SIGNATURE: Gertrude Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12985

CERTIFICATE OF DEATH

12990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - St. Michaels
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rio Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McDaniel,
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: HASTING — Last: DERBYSHIRE

4. DATE OF DEATH: Month: September — Day: 11, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 22, 1895

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Purchasing Agent

10b. KIND OF BUSINESS OR INDUSTRY: Engineering

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Edwin Derbyshire

14. MOTHER'S MAIDEN NAME: Laura Melville Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 185-03-0751

17. INFORMANT — Address: Mrs. Kathryn K. Derbyshire, McDaniel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO (b): Carcinoma of Kidney — 10 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c): Pathologic Fracture R Hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan, 1967, to Sept 11, 1967, that (I) (~~we~~) last saw the deceased alive on Sept 9, 1967 and that death occurred at 9:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R Lane Wroth M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-12-67

22c. PHYSICIAN'S NAME (Type): R. LANE WROTH, M. D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Spacify): Burial

23b. DATE THEREOF: Sept 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town or county) (State): Easton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Harrison E. Leonard St. Michaels Md.

25a. REC'D BY REGISTRAR DATE: SEP 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12991

1. PLACE OF DEATH
a. COUNTY: TALBOT 13986 — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 45 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ST. MICHAELS
d. STREET ADDRESS: GRACE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ERNEST Middle: M. Iton Last: DYOTT
4. DATE OF DEATH: Month: 9 Day: 17 Year: 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUG 31, 1890
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN
10b. KIND OF BUSINESS OR INDUSTRY: SEAFOOD
11. BIRTHPLACE (County & State, or foreign country): St. MICHAELS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES A. DYOTT
14. MOTHER'S MAIDEN NAME: MARY WILLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 212-16-1968A
17. INFORMANT: Ernest Dyott Address: St. Michaels Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mon
DUE TO (b): Chronic Nephritis — 10 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1967 to Sept 17, 1967, that (I) (we) last saw the deceased alive on Sept 17 1967, and that death occurred at 1:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/18/67
22c. PHYSICIAN'S NAME (Type): R. Lane Wroth
22d. ADDRESS: M.D. St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Oliver Cemetery
23d. LOCATION (City or Town) (County) (State): St. Michaels Maryland
24. FUNERAL DIRECTOR: Harrison E. Leonard ADDRESS: St. Michaels, Md
25a. REC'D BY REGISTRAR DATE: SEP 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judges

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12987 — 12992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the ottending physicion and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in ony event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Talbot
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 15HR. - 50 Min
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before odmission)
   a. STATE: MARYLAND
   b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Rt-1, Box 22A - Preston
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Lucille; Middle; Lost Green

4. **DATE OF DEATH**: Month Sept.; Day 25; Year 1967

5. SEX: Female

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-10-06

9. AGE (In years last birthday): 61 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): SAVANNAH, GEORGIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: CLARA BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
   (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 217-28-4219

17. **INFORMANT**: MARY ALICE WALLACE, Address R-1, Box 143 HURLOCK, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (o): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: < 24 hrs.
   DUE TO
   Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
   (b)
   DUE TO
   (c)

   331 X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-24, 1967, to 9-25, 1967, that (I) (we) last saw the deceased alive on 9-24 1967, and that death occurred at 9:50 AM, from causes ond on the dote stated above.

22a. SIGNATURE: Robert W. Trever M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-27-67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever, M.D.

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9-30-67

23c. NAME OF CEMETERY OR CREMATORY: FEDERALSBURG

23d. LOCATION (City or Town) Fed (County) burg (State): CAROLINE Co. Maryland

24. FUNERAL DIRECTOR: Barbara Dashiell

ADDRESS: 426 DOVER ST. EASTON, Md.

25a. REC'D BY REGISTRAR DATE: SEP 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12988 (M) 12993

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 1MO-9 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HOUSE IN THE PINES-EASTON, MD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Preston 05.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARGARET — Middle: B. — Last: HENNEY

4. DATE OF DEATH: Month: September — Day: 28 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 18-86

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Phila. Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Olge Schroeder

14. MOTHER'S MAIDEN NAME: Dorothea Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 431-20-0054

17. INFORMANT: Lt. Col. Martin Schroeder — Address: 4750 Kenmore Que. Alexandria, VA.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: > 6 wks.

1750

DUE TO (b): Metastatic adenocarcinoma — > 6 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): of the ovary

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 — **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ — **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19.....; that (I) (we) last saw the deceased alive on .....19....., and that death occured at 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — **23b. DATE THEREOF**: 9/30/1967 — **23c. NAME OF CEMETERY OR CREMATORY**: LAKEVIEW MEMORIAL PARK — **23d. LOCATION** (City, town or county) (State): MERCHANTVILLE, N.J.

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newman + Son — **ADDRESS**: Easton, Md.

25a. REC'D BY REGISTRAR — DATE: OCT 3 1967 — **25b. REGISTRAR'S SIGNATURE**: Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12989 Item #2b,c & d Film #G393 10/11/67 ph

CERTIFICATE OF DEATH

12994

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificote be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificote hos been signed by the ottending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in ony event, within 72 hours of the death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot
MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Oxford (rural)
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sailor's Retreat

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot/ ~~Balto.~~
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Oxford/ (rural) ~~Balto. 21204~~ 304
d. STREET ADDRESS: 5316 Gwynn Oak Ave. Sailor's Retreat
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edwin Middle: Eugene Last: Hooper
4. DATE OF DEATH: Month: 9/21 Day Year: 19 67
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/17/1884
9. AGE (In yeors lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pro. Baseball player & Coach
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel H. Hooper
14. MOTHER'S MAIDEN NAME: Adeline Kennard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 215-50-2939
17. INFORMANT: Address: Mrs. Edwin E. Hooper, Oxford, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH: Week
491X
DUE TO (b):
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying cause lost.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Parkinson's Dis.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
2

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Manth, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967, to 9/21, 1967, that (I) (we) last saw the deceased alive on 9/14 1967, and that death occurred at 5:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert M. McDonald M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/29/67
22c. PHYSICIAN'S NAME (Type): R. M. McDONALD M.D.
22d. ADDRESS: 25 S. Hanson St. Easton, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/25/1967
23c. NAME OF CEMETERY OR CREMATORY: Oxford
23d. LOCATION (City or Town) (County) (State): Oxford, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON, EASTON, Md.
ADDRESS
25o. REC'D BY REGISTRAR DATE: SEP 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12990

CERTIFICATE OF DEATH

12995

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: 509 GOLDSBOROUGH ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther; Middle: Virginia; Last: Hoxter

4. DATE OF DEATH: Month: 9; Day: 6; Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-2-93
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: xx
11. BIRTHPLACE (County & State, or foreign country): Q.A.Co. MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: B.L. THOMAS
14. MOTHER'S MAIDEN NAME: GEORGIA A. Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-3570
17. INFORMANT: T.O. HOXTER. Address: SEAFORD, DELAWARE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diffuse interstitial fibrosis of the lungs
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___ to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 9:55 p.m., from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/6/67
22c. PHYSICIAN'S NAME (Type): Robert W. Trever M. D.
22d. ADDRESS: Easton, Maryland 9/6/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: SEPT 10
23c. NAME OF CEMETERY OR CREMATORY: STEVENSVILLE
23d. LOCATION (City or Town) (County) (State): STEVENSVILLE Md.

24. FUNERAL DIRECTOR: Edgar L. Lane ADDRESS: Church Hill Md.
25a. REC'D BY REGISTRAR DATE: SEP 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12991 — 12996

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): St. Michaels (rural)
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Rio Vista Nursing Home

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Bellevue
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harold — Middle Francis — Lost Hutchinson, Sr.

4. DATE OF DEATH: Month 9/25 — Day — Year 19 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1/1/1882
9. AGE (In yeors lost birthdoy): 85 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairy Dept. Borden Co.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Kings N.Y.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John Hutchinson
14. MOTHER'S MAIDEN NAME: Catherine Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 067-05-5299
17. INFORMANT — Address: Harold F. Hutchinson, Jr. Bellevue, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3-4 mos
DUE TO (b): Ath. cardio & cerebrovasd
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse last.
DUE TO (c): 0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): cachexia, advanced senile change

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1961, 19__, to 9-25, 1967, that (I) (we) last saw the deceased alive on 9-25 1967, and that death occurred at 3:20 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-26-67
22c. PHYSICIAN'S NAME (Type): Guy M Reed Jr
22d. ADDRESS: St Michaels Md

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/29/1967
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park
23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON — ADDRESS: Easton, Md.
25o. REC'D BY REGISTRAR DATE SEP 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12992 12997

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JAMES Last Jackson

4. DATE OF DEATH: Month 9 Day 10 Year 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/21/89

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer C.S. Public Service

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Jackson

14. MOTHER'S MAIDEN NAME: Margaret Ann Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-09-4656

17. INFORMANT Address: Mrs. Fred Eberhard, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure
4222
DUE TO
(b): Myocardial hypertrophy
DUE TO
(c): Gangrene left leg
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___ to _____, 19___, that (I) (we) last saw the deceased alive on August 19___, and that death occurred at 6 p.m. M, from causes and on the date stated above.

22a. SIGNATURE: C.H. Schmidt
M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11 Sept 1967

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/13/1967

23c. NAME OF CEMETERY OR CREMATORY: Olivet

23d. LOCATION (City or town) (County) (State): St. Michaels, Md.

24. FUNERAL DIRECTOR ADDRESS: MAURICE E. NEWNAM & SON, Easton, Md.

25a. REC'D BY REGISTRAR DATE SEP 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

12993

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12998

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 11 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): NEWCOMB
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEVIN Middle: GUS Lost: KILMON, JR.

4. DATE OF DEATH: Month: Sept. Doy: 27 Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 31, 1904

9. AGE (If years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY: SEAFOOD

11. BIRTHPLACE (County & Stote, or foreign country): TALBOT COUNTY, MD

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: LEVIN GUS KILMON, SR.

14. MOTHER'S MAIDEN NAME: SARAH C. LARRIMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 215-20-0853

17. INFORMANT: FRANKLIN R. KILMON, Address: NEWCOMB, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral obstructive pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Massive Bronchogenic ca — INTERVAL: Mos.
DUE TO (c): —
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cachexia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospitol) attended the deceased from 9-5-67, 19__ to 9-28, 1967 thot (I) (we) last saw the deceased olive on 9-28 1967 ond thot death occurred at 11:25 M, from couses ond on the date stoted above.

22a. SIGNATURE: Guy M Reese Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-28-67
22c. PHYSICIAN'S NAME (Type): Guy M Reese Jr.
22d. ADDRESS: St Michaels Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: SEPT 30, A67
23c. NAME OF CEMETERY OR CREMATORY: OLIVET CEMETERY
23d. LOCATION (City or Town) (County) (Stote): ST. MICHAELS, MARYLAND

24. FUNERAL DIRECTOR: Harrison E. Leonard, ADDRESS: St. Michaels, Md

25a. REC'D BY REGISTRAR DATE: OCT 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12994

CERTIFICATE OF DEATH

12999

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 2days 9hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): Easton 20,1
d. STREET ADDRESS: 215 N. Locust St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Eric — Middle: — Last: Matzeit
4. DATE OF DEATH: Month: Sept. — Day: 2 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-12-10
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): barber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Heinrich Matzeit
14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 214-01-8149
17. INFORMANT: Address: Mrs. Mary A. Matzeit Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Carcinoma of the Colon — INTERVAL BETWEEN ONSET AND DEATH: 1YR
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-31, 1967 to 9-2, 1967 that (I) (we) last saw the deceased alive an 9-7 1967, and that death occurred at 8:30 M, from causes and on the date stated above.

22a. SIGNATURE: Harry M. Walsh, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-8-'67
22c. PHYSICIAN'S NAME (Type): Harry M.. Walsh, M.D.
22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 9/4/67
23c. NAME OF CEMETERY OR CREMATORY: Springhill
23d. LOCATION (City or Town) (County) (State): Easton, Talbot, Md.

24. FUNERAL DIRECTOR: Jay D. Heverin — ADDRESS: Easton, Md.
25a. REC'D BY REGISTRAR DATE: SEP 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12995

CERTIFICATE OF DEATH

13000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cordova
d. STREET ADDRESS: Box 14
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Gustav; Middle: ; Last: Mende

4. **DATE OF DEATH**: Month: Sept.; Day: 3; Year: 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 16, 1893

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Maxmillian Mende

14. MOTHER'S MAIDEN NAME: Helene Nette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-36-1426

17. **INFORMANT** Address: Mrs. Gustav Mende, Cordova, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEPATIC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO
(b): CA. COLON & L. KIDNEY WITH — 1 YEAR
DUE TO
(c): HEPATIC & PULMONARY METASTASES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-25, 1967 to _____, 19__, that (I) (we) last saw the deceased alive on 9-2 1967, and that death occurred at 7:45 AM, from causes and on the date stated above.

22a. SIGNATURE: John Knud-Hansen — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/5/67

22c. PHYSICIAN'S NAME (Type): John Knud-Hansen M.D.

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/5/1967

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park

23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: Maurice E. Newnam & Son

ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE: SEP 7 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12996 13001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - St. Michaels
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rio Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Stood~~ Royal Oak,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA — Middle FRANKEM — Last PERKINS

4. DATE OF DEATH: Month, Day, Year: September 20, 1967

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 21, 1879

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Harrisburg, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward F. Frankem

14. MOTHER'S MAIDEN NAME: Sarah Ann Spousler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No ----

16. SOCIAL SECURITY NO.: - -

17. INFORMANT: Address: Records - Rio Vista Nursing Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2wks
DUE TO (b): Arteriosclerotic Cardiovascular Dis 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chol. Illness - Cholecystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(his hospital)~~ attended the deceased from 6-23, 1938 to 9-20, 1967 that (I) (~~we~~) last saw the deceased alive on 9-19, 1967, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-21-67

22c. PHYSICIAN'S NAME (Type): R. LANE WROTH, M. D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Sept. 23, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery — 23d. LOCATION (City, town or county) (State): St. Michaels, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harrison E. Leonard — ADDRESS: St. Michaels Md.

25a. REC'D BY REGISTRAR — DATE: SEP 26 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12997

CERTIFICATE OF DEATH

13002

1. **PLACE OF DEATH**
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Easton Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro, Maryland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Charles — Middle — Last Pinder

4. **DATE OF DEATH**: Month Sept. — Day 21 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/15/1902

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Queen Anne's Co.Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Steve Pinder

14. MOTHER'S MAIDEN NAME: Alice Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give wor or dates of service): No

16. SOCIAL SECURITY NO.: 213-24-1640

17. **INFORMANT** Address: Mrs.Mary Hines Goldsboro,Md.

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Bladder Grade III
DUE TO (b) Metastasis to Pelic Nodes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-13, 1967, to 9-21, 1967, that (I) (we) last saw the deceased alive on 9-21 19 67, and that death occurred at 5:42 M, from causes and on the date stated above.

22a. SIGNATURE John N Robinson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 9.22.67

22c. PHYSICIAN'S NAME (Type) John N. Robinson M.D.

22d. ADDRESS Easton, Maryland 9/22/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/1967

23c. NAME OF CEMETERY OR CREMATORY: Roseville Cemetery

23d. LOCATION (City or Town) (County) (State): Near Prices Queen Anne's, Md

24. FUNERAL DIRECTOR — ADDRESS: Kenneth Dolby Chas Town, Md

25a. DATE: SEP 27 1967

25b. REGISTRAR'S SIGNATURE: Josephine Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

12998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): CONOVA
c. LENGTH OF STAY IN 1b: 23 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): CONOVA 20.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Marguerite — Middle: ROE — Lost: Milby

4. DATE OF DEATH: Month: Sept. — Day: 9 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Nov. 4, 1896
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Queen Anne Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Franklin Milby
14. MOTHER'S MAIDEN NAME: Mary Andrews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 218-16-9015
17. INFORMANT: Address: Mrs. Jervis Cooke, Newark, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary artery disease — 4 years
DUE TO (c):
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 13, 19__, to May 67, 19__, that (I) (we) last saw the deceased alive on May 15 19 67, and that death accurred at ____M, from causes and on the date stated above.

22a. SIGNATURE: Kurt Lederer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-9-67
22c. PHYSICIAN'S NAME (Type): KURT LEDERER
22d. ADDRESS: QUEEN ANNE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/9/1967
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill
23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON, Easton, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: SEP 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12999

CERTIFICATE OF DEATH

13004

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro
d. STREET ADDRESS: Sunset Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Marie Last: Shanahan
4. DATE OF DEATH: Month: 9 Day: 26 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-30-1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Coyle
14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 114-07-2751
17. INFORMANT: Dorothy Shanahan Address: Greensboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cerebral Hemorrhage
331X
DUE TO
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: <24 Hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19__, that (I) (we) last saw the deceased alive on 9/26 1967, and that death occurred at 7 P M, from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever
M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-30-67
23c. NAME OF CEMETERY OR CREMATORY: Greensboro
23d. LOCATION (City or Town) (County) (State): Greensboro, Maryland

24. FUNERAL DIRECTOR: J. E. Boulais
ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: SEP 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Brother
Robert Slaughter
Williamsburg 3425

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #2a & 9 Filmed 393 9/25/67 ph

CERTIFICATE OF DEATH

13005

1. **PLACE OF DEATH** — a. COUNTY: Talbot — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton — c. LENGTH OF STAY IN 1b: 11

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) — a. STATE: MD. — b. COUNTY: TALBOT — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON — d. STREET ADDRESS: Graham Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.

3. **NAME OF DECEASED** (Type or print): First: Nathan — Middle: — Last: Slaughter

4. **DATE OF DEATH**: Month: Sept. — Day: 17 — Year: 19 67

5. SEX: MALE — 6. COLOR OR RACE: NEGRO — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 8. DATE OF BIRTH: 11-27-1901 — 9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER — 10b. KIND OF BUSINESS OR INDUSTRY: MILL (GRAIN) — 11. BIRTHPLACE (County & State, or foreign country): TALBOT - MD. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NATHAN SLAUGHTER — 14. MOTHER'S MAIDEN NAME: MARY FRANCIS MURRAY MD-

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service) — 16. SOCIAL SECURITY NO.: 219-01-0777 — 17. INFORMANT: ROBERT SLAUGHTER — Address: TRAPPE, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 week

DUE TO (b): arteriolosclerotic renal disease — many yrs

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

446 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 Sep, 1967 to 17 Sep, 1967 that (I) (we) last saw the deceased alive on 9/17 1967, and that death occurred at 10 p M, from causes and on the date stated above.

22a. SIGNATURE: Stephen P. Carnery — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-18-67

22c. PHYSICIAN'S NAME (Type): Stephen P. Carnery, M.D.

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 9-21-67 — 23c. NAME OF CEMETERY OR CREMATORY: IVORY TOWN — 23d. LOCATION (City or Town) (County) (State): EASTON RURAL - TALBOT MD

24. FUNERAL DIRECTOR: Barbara D — ADDRESS: Trappe, Md.

25a. REC'D BY REGISTRAR DATE: SEP 20 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2 infor, taken from birth cert. ph

13001

CERTIFICATE OF DEATH

14514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 10 mm
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Caroline ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgely
d. STREET ADDRESS: 401 Central Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY Middle: Girl Last: Shoaf

4. DATE OF DEATH: Month: 9 Day: 8 Year: 1967

5. SEX: F

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/8/67

9. AGE (In years last birthday) — yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Easton, Md. Memorial Hospital

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Joseph A. Shoaf

14. MOTHER'S MAIDEN NAME: Mary White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary Shoaf Address: Ridgley, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immature Infant
776X
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__ to ____, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 11:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: E.D. Hardy — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 10/9/67

22c. PHYSICIAN'S NAME (Type): E. D. Hardy M.D. — 22d. ADDRESS: Easton, Maryland — 10/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Inurnation — 23b. DATE THEREOF: 9/11/67 — 23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital — 23d. LOCATION (City or Town) (County) (State): Easton, Maryland

24. FUNERAL DIRECTOR: Memorial Hospital, Easton, Maryland — ADDRESS

25a. REC'D BY REGISTRAR DATE: OCT 10 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

T-275050

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13002 13006

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Preston
d. STREET ADDRESS: R.F.D. # 2 - Box 102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEROY Leroy; Middle WHITE White; Last SPRINGS Spring
4. DATE OF DEATH: Month 9; Day 9; Year 1967
5. SEX: male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 16,1936
9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Canning Factory
11. BIRTHPLACE (State or foreign country): Jacksonville, Florida
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Matthew White
14. MOTHER'S MAIDEN NAME: Florida Mae Springs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 220-32-8396
17. INFORMANT Address: Florida Mae Ross, Preston, Md., RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Irreversible Shock From External Hemorhage — INTERVAL BETWEEN ONSET AND DEATH: 6hrs
DUE TO (b): Also possible internal hemorhage — 6hours
DUE TO (c): Compound Comminuted fracture humerus — 6hours
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse last.
8124

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ? Alcoholism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Hit & run Route 318 between Preston&Federalsburg
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. ? A.M. p.m. 9/9.67 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): As above
20f. (City or town) (County) (State): Federalsburg Caroine Md

21. I certify thot I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Notural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Harold B. Plummer M.D
EXAMINER'S NAME (Type): Harold B.Plummer M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Preston Maryland
22. DATE SIGNED: 9/12/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept.16,1967
23c. NAME OF CEMETERY OR CREMATORY: Jonestown Cemetery
23d. LOCATION (City or Town) (County) (State): Near Preston, Maryland

24. FUNERAL DIRECTOR ADDRESS: Frampton Funeral Home Federalsburg Maryland.
25a. REC'D BY REGISTRAR DATE: SEP 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13003 Item #"b,c & d 1 Im #0393 10/3/67 ph 13007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 3 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Home for Aged Women

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: ~~Talbot~~ Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Easton~~ Towson
   d. STREET ADDRESS: Eudowood Sanatarium employee of the Sanatarium
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First INA Middle HIGGINS Last STANGE

4. DATE OF DEATH: Month September Day 11 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 4, 1887

9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse & Teacher

10b. KIND OF BUSINESS OR INDUSTRY: State Sanitarium

11. BIRTHPLACE (County & State, or foreign country): St. Michaels, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Higgins

14. MOTHER'S MAIDEN NAME: Henrietta Frampton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No ----

16. SOCIAL SECURITY NO.: 212-32-4150

17. INFORMANT: Albert E. Stange, 4501 Mainfield, Address Baltimore, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Some yrs.

332x

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Hemorrhagic Cystitis & Bladder Carcinoma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug., 1967, to Sept. 11, 1967, that (I) (we) last saw the deceased alive on Sept. 11 1967, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert M. McDonald M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/11/67

22c. PHYSICIAN'S NAME (Type): Robert M. McDonald MD.

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Harrison E. Leonard ADDRESS St. Michaels, Md.

25a. REC'D BY REGISTRAR DATE SEP 18 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A1S (4)
20M 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14508 14519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - St. Michaels
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ----

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - St. Michaels
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: JAMES Last: THOMAS

4. DATE OF DEATH: Month: September Day: 30 Year: 19 67

5. SEX: Male

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Aug 18, 1870

9. AGE (In years last birthday): 97 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): St. Michaels, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wilson Thomas

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): ----

16. SOCIAL SECURITY NO.: 218-30-1190

17. INFORMANT: William H. Thomas, Address: Rt #1, Box 161 St. Michaels, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cachexia - many months
DUE TO (b): severe atherosclerotic cardio
DUE TO (c): + cardiovasc.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): advanced senile changes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1953, 19..., to 9-30-67, 19..., that (I) (we) last saw the deceased alive on 9-30-67, and that death occurred at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Guy M. Reeser Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-3-67

22c. PHYSICIAN'S NAME (Type): GUY M. REESER, Jr., M. D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: Thomas Memorial Cemetery

23d. LOCATION (City, town or county) (State): St. Michaels, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harrison E. Leonard, St. Michaels Md

25a. REC'D BY REGISTRAR DATE OCT 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15 (4)
20M 5-63

9-30-62

10-3-62

13004

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G393 9/27/67 ph

12 10 a.m.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13008

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH a. COUNTY: Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton c. LENGTH OF STAY IN 1b: D.O.A d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McDaniel 20-1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Earl	Samuel	Turner	Sept	16	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro	MARRIED X	Nov. 7, 1929	37 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waterman		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Theophlius Murray	Catherine Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes	220-26-3989	Leonard Palmer St. Michaels, M d.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): G.S.W. Chest — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
981 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
	shot during altercation in bar

20c. TIME OF INJURY Month, Day, Year Hour	20d. INJURY OCCURRED While at work ☐ Not While at work X	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
11:30 p.m. 9-16 1967		bar	StMichaels Talbot Md

21. I **certify** that I took charge of the remains described above, held on Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Notural couses ☐, Accident ☐, Suicide ☐, Hamicide X, Undetermined manner ☐

ACTUAL SIGNATURE: Louis O Welty M.D. for
EXAMINER'S NAME (Type): Welty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
Address (Street, city, town, or county)

22. DATE SIGNED: 9-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-22-67	Claiborne	Claiborne Talbot Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
B.L. Dashiell Easton, Md.	SEP 20 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13005 Item#1d Film #G393 10/2/67 pm — 13009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 2 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 520 N. Washington St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Dor.
c. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
d. STREET ADDRESS: Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maude — Middle: Ellis — Last: Venables

4. DATE OF DEATH: Month: 9 — Day: 18 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/2/1896

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owned & Operated a Rest Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Ellis

14. MOTHER'S MAIDEN NAME: Lizzie Spear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Lloyd Christopher — Address: Easton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 10mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of the endometrium — 3 yrs
DUE TO (c):

172X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis enlarged varicosites both legs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-14, 1953, to 9-18, 1967, that (I) (we) last saw the deceased alive on 9/16/67, 1967, and that death occurred at 5:4 M, from the causes and on the date stated above.

22a. SIGNATURE: Harold B Plummer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-19-67

22c. PHYSICIAN'S NAME (Type): Harold B. Plummer M.D.

22d. ADDRESS: Preston Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/20/67

23c. NAME OF CEMETERY OR CREMATORY: Firemans

23d. LOCATION (City, town or county) (State): Sharptown, Md

24. FUNERAL DIRECTOR ADDRESS: Ruth S. Willoughby, East New Market, Md

25a. REC'D BY REGISTRAR DATE: SEP 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13006 13010

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): St. Michaels
c. LENGTH OF STAY IN 1b: 9 mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ------

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
d. STREET ADDRESS: Chestnut St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle NATHANIEL — Last WATTS

4. DATE OF DEATH: Month September — Day 18, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 13, 1902

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist

10b. KIND OF BUSINESS OR INDUSTRY: Drugs

11. BIRTHPLACE (County & State, or foreign country): Talbot County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles D. Watts

14. MOTHER'S MAIDEN NAME: Annabelle Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — WW II

16. SOCIAL SECURITY NO.: 169-03-9851 A

17. INFORMANT: Mrs. Gertrude Watts, Address 1022 Woodson Rd., Baltimore, Md. 21212

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min
DUE TO (b): Arteriosclerotic Cardiovascular — years
DUE TO (c): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Cardiomegaly

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Sept. 9, 19 67, to Sept. 18, 19 67, that (I) (~~we~~) last saw the deceased alive on Sept. 18, 1967, and that death occurred at 5:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Lame Wroth M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-19-67

22c. PHYSICIAN'S NAME (Type): R. Lame Wroth, M. D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harrison E. Leonard — ADDRESS: St. Michaels Md.

25a. REC'D BY REGISTRAR DATE: SEP 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (7)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13007

CERTIFICATE OF DEATH

13011

1. PLACE OF DEATH
a. COUNTY Talbot
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 2hr. 10 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY TALBOT
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) ST. MICHAELS
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Eva Middle Mae Last Willey
4. DATE OF DEATH Month 9 Day 12 Year 1967
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 4, 1897
9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (County & State, or foreign country) PARKTON, MD
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARRY ENSOR
14. MOTHER'S MAIDEN NAME JENNY ELIZABETH HECK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No
(If yes give war or dates of service) —
16. SOCIAL SECURITY NO. 29-09-0300
17. INFORMANT Address EDWARD WILLEY, ST. MICHAELS, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO (b) Small cell carcinoma of Lung, Primary
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 194X
INTERVAL BETWEEN ONSET AND DEATH 2 days, 9 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb, 1967, to Sept 12, 1967, that (I) (we) last saw the deceased alive on Sept 12, 1967, and that death occurred at 9:4 M, from causes and on the date stated above.

22a. SIGNATURE R. Lane Wroth
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9-13-67.
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth M.D.
22d. ADDRESS St. Michaels, Maryland 9/13/67

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF SEPT 15, 1967
23c. NAME OF CEMETERY OR CREMATORY Oliver Cemetery
23d. LOCATION (City or Town) (County) (State) St. Michaels Md.
24. FUNERAL DIRECTOR Harrison E. Leonard
ADDRESS St. Michaels
25a. REC'D BY REGISTRAR DATE SEP 18 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13008

CERTIFICATE OF DEATH

13012

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. — b. COUNTY: QUEEN ANNE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRASONVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: H — Last: Wilson

4. DATE OF DEATH: Month: Sept — Day: 12 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-11-90

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): QUEEN ANNE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL WILSON

14. MOTHER'S MAIDEN NAME: MYRA CARTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 220-07-0074

17. INFORMANT: Address: GEORGE WILSON, JR. - GRASONVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: (?)
DUE TO
(b): Atherosclerotic nephropathy — (?)
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
446 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED White at work ☐ Nat White at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 29 Aug, 1967, to 12 Sept, 1967 that (I) (we) last saw the deceased alive on 12 Sept 1967, and that death occurred at 7 pM, from causes and on the date stated above.

22a. SIGNATURE: Thurston Harrison — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 14 Sept 67

22c. PHYSICIAN'S NAME (Type): THURSTON HARRISON

22d. ADDRESS: Easton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9-16-67

23c. NAME OF CEMETERY OR CREMATORY: GRASONVILLE

23d. LOCATION (City or Town) (County) (State): GRASONVILLE - QUEEN ANNE MD

24. FUNERAL DIRECTOR: Dashiell Funeral Home — ADDRESS:

25a. REC'D BY REGISTRAR DATE: SEP 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

A34
10/19/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13009

CERTIFICATE OF DEATH

13013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: md. — b. COUNTY: Q.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
d. STREET ADDRESS: R+D #1 Box 23
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LIDA — Middle: M — Last: WRIGHT

4. DATE OF DEATH: Month: 9 — Day: 10 — Year: 19 67

5. SEX: Fe

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-15-11

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM DAWKINS

14. MOTHER'S MAIDEN NAME: LUCY MACKABEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MRS. WALTER O'HALL, CENTREVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma
DUE TO
(b): of the cervix
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
171X
INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive an _____ 19__, and that death occurred at 5:40 p M, from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/11/67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M. D.

22d. ADDRESS: Easton, Maryland 9/11/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: SEPT. 13, 1967

23c. NAME OF CEMETERY OR CREMATORY: BRIDGEVILLE

23d. LOCATION (City or Town) (County) (State): BRIDGEVILLE DEL.

24. FUNERAL DIRECTOR: Charles V. Moore — ADDRESS: Denton Md

25a. REC'D BY REGISTRAR DATE: SEP 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge